

right ovary and all but 2 cm. of the right tube were absent. The lower border of the omentum was enormously thickened and was wrapped completely around a tumor 15 cm. in diameter. On enucleation this was found to be a dermoid of the right ovary containing teeth, hair, and sebum.

New Formation of the Female Urethra.—NOBLE (*American Journal of Obstetrics*, vol. xliii.) reports a case in which eleven unsuccessful operations had been performed for cure of a urethral fistula. The entire wall of the urethra was destroyed, and a fistula existed involving the neck of the bladder. The situation of the urethra was marked by a strip of mucous membrane continuous above with the vesical wall. The opening into the bladder was large enough to admit the index finger. The edges of the fistula were cicatricial, and upon each side of the urethra were extensive cicatrices, probably due to incisions made at the various operations to relieve tension on the sutures. After two unsuccessful attempts to form a new urethra, owing to the extreme tension on the sutures, the following procedure was successfully carried out: In order to increase the retentive power of the bladder the urethra was elongated so that the meatus should be at the clitoris instead of at the normal site. The internal coat of the urethra was made from the mucous membrane of the vestibule and the remains of the urethral mucous membrane. This was sufficiently loosened, after parallel longitudinal incisions had been made, so that it could be united over a Sims sigmoid catheter (one-third the usual calibre). This catheter was left *in situ* for ten days. The raw surface at the sides of the urethra and over the neck of the bladder were widened. An incision was made along the inner base of the left labium minus, and the labium detached from the subjacent structure and unfolded. This flap was drawn back into the vagina, covering over the urethra and then united by interrupted sutures to the edges of the raw surface. At the anterior end of the new urethra the lateral edges of the labia minora were united, firm union was obtained, and the bladder function was restored.

Etiology of Movable Kidney.—WATSON (*Boston Medical and Surgical Journal*, vol. cxlv., No. 12) conducted a series of experiments on the cadaver to determine the structures chiefly concerned in the fixation of the kidney. Twelve cadavers in which death occurred not longer than twenty-four hours previously, and in which the kidneys and their surroundings presented no abnormal changes, were used in the investigation.

After opening the abdomen downward traction was made by the finger tips upon the upper pole of the kidney with as little disturbance as possible to the neighboring tissues. The descent of the organ was from half an inch to an inch and a half. The outer leaf of the mesocolon was then divided and the colon and other viscera overlying the kidney were drawn inward. The descent of the kidney under traction was now increased by half an inch. Next, the fatty tissue in front of and beneath the lower end of the kidney was removed, but with no appreciable effect upon its mobility. The removal of that portion of the peritoneum which on the right side forms an actual peritoneal investment of the upper portion of the kidney, and is reflected from it onto the duodenum and stomach, permitted a further descent of a

quarter to half an inch. Thus, after removal of all the structures in relation with the anterior surface and lower end of the kidney, the descent of the organ had not exceeded the lowest point of its normal excursion by more than three-quarters of an inch in any case.

The structures connected with the posterior surface and upper pole of the kidney were now broken down, beginning above the upper pole of the organ. Further descent occurred in direct proportion to the destruction of these tissues, the movement finally becoming entirely free except for the restraint exercised by the main bloodvessels, whose action drew it toward the spinal column. These experiments seem to harmonize with the anatomical studies of Gerota and others, and the author comes to the following conclusion: The structures vital to the restriction of the kidney's mobility within its normal excursion are those which form the attachments between the posterior and upper aspect of the tunica propria, and the fascia covering the lumbar muscles and the peritoneum covering the diaphragm respectively, aided by the less essential ones connecting the anterior surface with the peritoneum overlying it.

OBSTETRICS.

UNDER THE CHARGE OF

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Three Successful Cesarean Sections.—KERR (*Medical Press*, November 6, 1901) reports three successful Cesarean sections in the Glasgow Maternity Hospital. He prepares the patient by thorough aseptic precautions, scrubbing the cervix and vagina with lysol, 1 per cent. In each of the cases labor was in progress and each patient was sterilized by tying the Fallopian tubes in two places and dividing them between the ligatures. In one case sterilized silk was used to close the womb, and in the other two catgut. Elastic tubing was not used to control the bleeding, but a vulcanite ring was employed to prevent hemorrhage when the uterus was opened.

His first case was that of a multipara in her third pregnancy, her other labors having been terminated by craniotomy. The os was fully dilated and the membranes ruptured, but the pelvis was contracted and the head freely movable above the brim. This patient's convalescence was interrupted by a severe bronchitis, occasioned by the irritation of chloroform, and also of coal-gas with which the building was lighted. The patient and her child made a good recovery.

The second case was a primipara with contracted pelvis. The child was dead, and no trace of heart action could be discovered. The patient made a good recovery, but had very scanty lochial discharge and a somewhat